Figure 1. Resident Patient Safety Incident Discussion Tool: *Example of a completed form.*

Resident Patient Safety Incident Discussion Tool

Identifying contributing factors*: 1. Start with the "**Problem**" box on the right: What is the key problem in this incident? 2. Next, identify all the factors that you think contributed to this problem..

Date: _____

*Note: please do not include patient identifiers on this form.

Cause ---------- Effect

Equipment/place

- Automatic scale in lbs but dosing in kgs
- Urgent care clinic, not usual clinic

Providers

- Stress due to time pressure, patients waiting

Patients

- Kids in the room noisy and distracting
- Parents wanted weight in lbs

Problem

Child prescribed more than twice the recommended dose of amoxicillin based on weight in lbs instead of kgs

- Requirement to calculate dose

Processes/procedures

Policies

Social determinants of health

What changes would you recommend to prevent this from happening again?

- *On a personal level*

  Document units on weight, create a space where I can concentrate, review prescriptions with patient

- *At a systems level (clinic, department, hospital, health care system)*

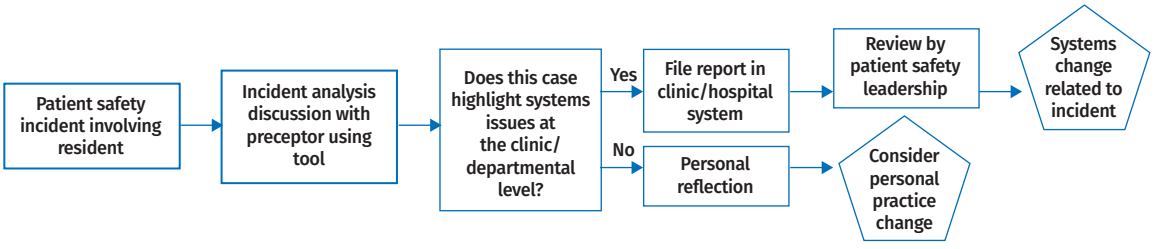
  Electronic medical record system that automatically includes weight on prescription for children (clinic scales to display weight in kgs).

Has this incident been disclosed to the patient? ☑ Yes ☐ No

How was this incident resolved or what are the next steps?

Error identified by supervising physician and corrected before it reached the patient

Does this incident need to be reported on your clinic/hospital reporting system (if applicable)? *(Please see decision aid below)* ☑ Yes ☐ No ☐ Not applicable



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